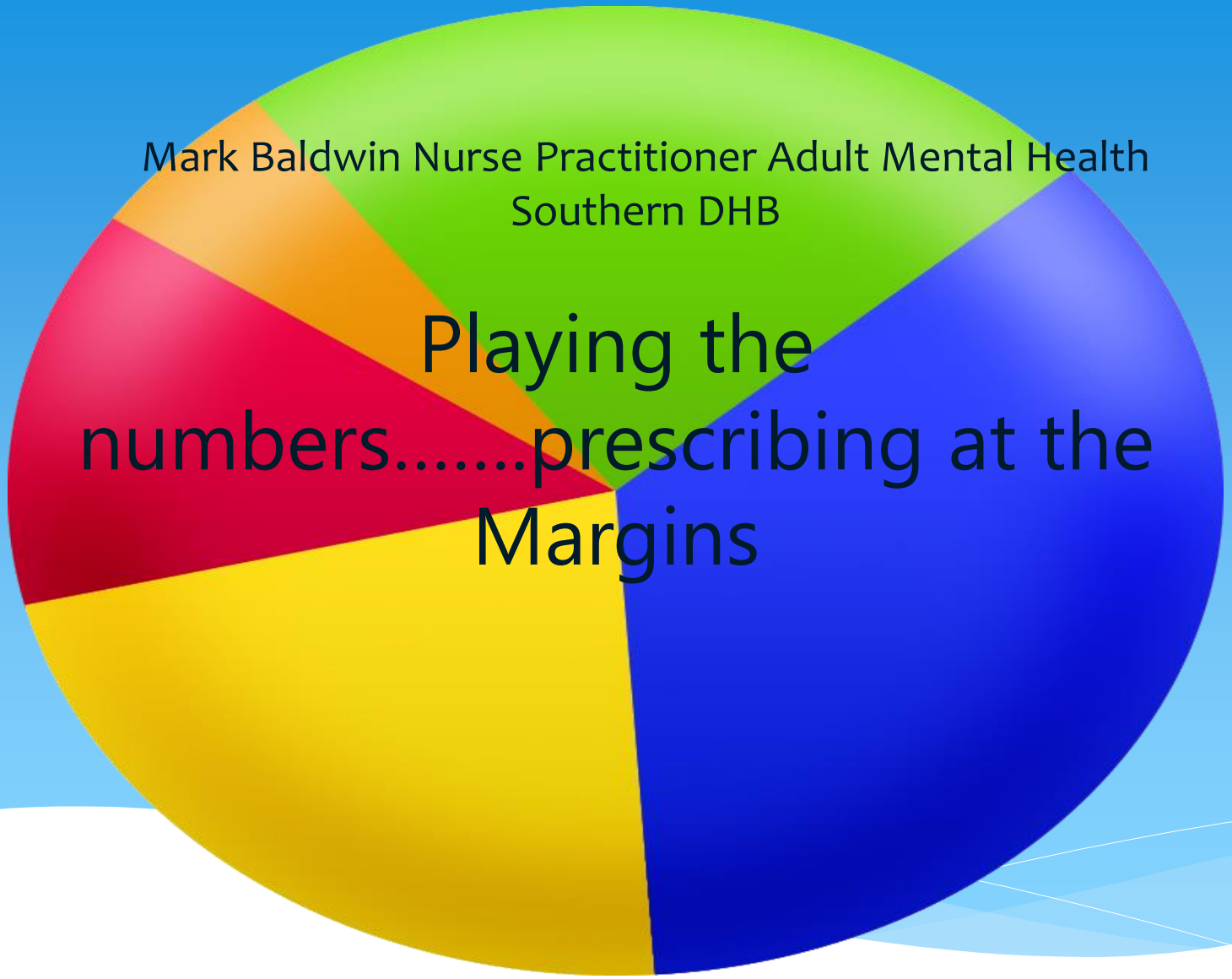
Mark Baldwin Nurse Practitioner Adult Mental Health
Southern DHB

Playing the numbers…….prescribing at the Margins



One Clinician
One Service Model

- Nurse Practitioner takes on the clinical management role from Nurses/Allied health and Prescribing role from Psychiatrists.

- Nurse Practitioner also takes on the role of Responsible Clinician under the Mental Health Act.

The Theory

* The role is grounded in the Ministry of Health's priorities and recommendations for provider arm mental health services to:
* "strengthen the alignment" with NGO providers
* "working together" more collaboratively
* "strengthen the capability of NGO's"
* "building better linkages"
* "more integrated" and "responsive" service
* "better meet the unique needs of this population group"
* (Te Kokiri and Te Tahuhu: Improving mental Health 2005-2015)

The clientele

* NGO with 3 Adult Mental Health sites- not all patients under my care, some under Forensic team, Early intervention or have remained under the CMHT care
* One rest home level residence
* One private supported accommodation provider
* One Trinza (3 monthly Paliperidone injection) patient, independent living

Assessment to determine housing need

- **Current psychiatric symptoms and effects on social functioning**
- • Strengths: work, hobbies, interests, relationships with friends and family
- • **Lifestyle issues: alcohol and substance use, smoking**
- • Recovery factors: hope, aspirations, motivation for independence and self-management
- • Personal preferences for accommodation type, location, support
- • Forensic issues: any previous problems with tenancy or disturbed behaviour in community
- • Engagement with services, including employment and educational needs
- • **Living skills, including ability to self-care, cook, shop, care of environment**
- • Physical health and any specific needs owing to physical disability
- • Carer assessment (where appropriate)

Tom Main
The Ailment (1957)

* "…no matter what the rationale was, a nurse would give a sedative only at the moment when she had reached the limit of her human resources and was no longer able to stand the patient's problems without anxiety, impatience, guilt, anger, or despair. A sedative would now alter the situation and produce for her a patient who, if not dead, was at least quiet and inclined to lie down, and who would cease to worry her for the time being. (It was always the patient and never the nurse that took the sedative)."

Patient A

* Mr A is a 56 year old, single New Zealand European male who resides in a 3 bedded private supported accommodation setting. He has been resident there for nearly 4years after 2 previous placements failed due to behavioural challenges. Previously living with his elderly mother and sister (youngest sibling), with frequent respite admissions to residential care for Mr A, until it was felt Mother and Sister were no longer capable for caring for him.

Patient A continued

- first presented to Mental health services in 1982, the year after his Father had died of a brain tumour.
- OCD checking facial features in mirror 10-15mins multiple times per day. Would pick at his hands and face (his father's face changed as the tumour progressed).
- Difficulty making decisions
- Ruminations about an unrequited love with a girl at university (studying accounting).

Patient A cont-2

* No sexual or relationship history
* Brief period of part-time work in 1983/4 but only sheltered work placements since then
* Long-term beneficary

Patient A cont-3

- Initially prescribed ‘a neuroleptic and anti-depressant’
- Diagnosis changed in 1983 to Schizoaffective disorder and started on Anafranil (Clomipramine TCA) 50mg nocte; Perphenazine (Phenothiazine anti-psychotic) 4mg noon, 3mg nocte (22/4/83 became 8mg nocte) and Benzhexol b.d.for side-effects.

Patient A cont-4

* Delusions of grandeur (1987)stating was a genius, plays some part in God's plan. Also ideas of reference from the TV and radio, thought insertion and passivity phenomena.
* Auditory hallucinations (late 1987) Jesus Christ telling him he was evil, and voice of god talking to him, also of the believing that he had to read the bible aloud- at one point seeking admission as he was not allowed to read the bible aloud at home.
*
* late 1988 Wayne reporting being under the power supernatural force, possessed by 4 evil spirits. 1991 Wayne voices of females from the afterlife wanting to marry him, command hallucinations from God and a clear description of being possessed by evil spirits, not helping God out properly, God didn't trust him and God didn't like him masturbating.
* April 1992 told by God that the voices would stop in January/February 1994 and that he would be able to walk by August 1992 and when he walked the possession by the Holy spirit would end- He also believed he would marry and have babies in the next lifetime. There were female voices, including Marilyn Monroe who wanted to marry him.
*
* In early 2002 the voices began to tell him that he had brain cancer (like his father) and also in his right jaw, throat and right knee. Voices were also persecutory telling him that he is ugly, a waste of time, that he had no friends and was the most hated person in all creation.

Pharmacology

* In June 1984 Parnate (Tranylcypromine- MAOI anti-depressant) was started at 10mg B.D. and then in July 1984 increased to 10mg TDS. In August 1984 switched to Nardil (Phenelzine - MAOI) 15mg TDS increasing to 20mg TDS.

Incident

Southern District Health Board

* Large overdose of the MAOI (84x 10mg Parnate) in January 1985 whilst on leave from hospital.
* Two week coma
* Thought he could save the world by committing suicide (Christian)
* Diagnosis of 'persistent organic psychosyndrome' with frontal disturbance, (usually involving involuntary laughter, disinhibition etc.)

'persistent organic psychosyndrome'

* **Psychoorganic syndrome** (**POS**), also known as **organic psychosyndrome,** is a progressive disease comparable to presenile dementia. It consists of psychopathological complex of symptoms that are caused by organic brain disorders that involve a reduction in memory and intellect. (wikipedia)

Pharmacology-2

* I took over Mr A's care in June 2017 after his long-standing psychiatrist retired.
* Drug regimen I inherited:
* Olanzapine 10mg mane, 10mg lunch, 20mg nocte (Max dose 20mg/day)
* Risperidone 1mg QID
* Risperidone 4mg nocte.(Total 8mg day, plus PRN ~ 11mg/day
* (doses above 10 mg daily only if benefit considered to outweigh risk (maximum 16 mg daily))

Pharmacology-3

Southern District Health Board

* Many medications have been trialled in the past:
* Feb 1987 was:
* Doxepin 225mg nocte (stopped May '92); Loxapine 50mg TDS and 150mg nocte (dose reductions in preparation for it's withdrawal from the market in June '98); Depixol 40mg IMI 2/52 (stopped Dec'92)
* Oct '87 Thioridazine 150mg B.D. and 300mg nocte
* Nov '87 Trifluroperazine 20mg TDS
* Back to Loxapine end Nov '87
*

Pharmacology-3

* Olanzapine Aug ‘98-Mar ‘99
* Risperidone Mar ‘99-Oct 2013 , Mr A was stable on this dose for many years, still persecutory auditory hallucinations
* Admission- Oct ‘13 swapped to Olanzapine 20mg b.d. (multiple admissions 2013). Methotrimeprazine 50mg QID added as regular med (one month)

Current Presentation

* Mr A presented with low mood in may 2018, Mother had died late 2016.
* Escitalopram 5mg increasing to 10mg, mood elevated, increased maniacal laughing
* Escitalopram was titrated to a stop.
* Sodium valproate added due to the 'mixed mood' symptoms slowly titrated up to 800mg b.d
* Risperidone was slowly titrated down, by reducing the nocte dose to 3mg and then removing the daytime doses.

Current presentation- 2

* PRN Risperidone stopped in January 2019
* PRN Olanzapine introduced by reducing the nocte dose to 15mg and allowing for 2x 2.5mg PRN doses.
* Recent introduction of Amisulpride

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Where to from here?

* Back to the future ?

* Diagnosis of ‘persistent organic psychosyndrome’ in 1985

PBA

- Pseudobulbar affect:
- Neurologic condition characterised by episodes of crying or laughing that are sudden, frequent, stereotyped, involuntary and exaggerated and/or incongruent with the intensity of stimulus provided.
- Occurs in TBI, MS, PD, ALS, Stroke and other neurologic conditions
- Disruption of the cortico-limbic-subcortical-thalamic-pontocerebellar network

PBA-2

- Pathologic laughing more common in men and those with right sided lesions
- Rough prevalence 10-38% in the 6 conditions
- Serotonin deficiency, dopamine deficiency, glutamate excess and sigma type 1 receptor (modulates calcium signalling) abnormalities all implicated

PBA-3

- Two rating scales:
- The Center for Neurologic Study-lability scale (CNS-LS) – self report measure for screening, and response to treatment
- Pathological Laughter and Crying Scale (PLACS) interviewer administered questionnaire (sensitivity 0.88, specificity 0.96)

PBA-4

* Treatment options:
* Citalopram and Sertraline have most evidence from SSRI class
* Case reports for SNRI's
* Small trials with TCA's Amitriptyline and Nortriptyline and some evidence for Imipramine
* Less evidence for Lamotrigine, Quetiapine, Aripiprazole, Levo-dopa and Amantadine

PBA-5

* FDA approved Dextromethorphan/Quinidine (DM/Q, 20-10mg)

* DM non-competitive antagonist of NMDA receptor and sigma 1 agonist. (*Robitussin*). *Binds to SERT and 5HT 1B/D receptor*

* Quinidine inhibits metabolism by CYP450 2D6

Questions/Thoughts?